



Student Information (Please print)

Name: _____ Date of Birth: _____
 Email: _____ Phone: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Emergency Contact: _____ Phone: _____

School Information

School Name: _____ Contact Person: _____
 Phone: _____
 Address: _____
 City: _____ State: _____ Zip: _____

Area of Preference:

- | | | |
|--|--|--|
| <input type="checkbox"/> Nursing | <input type="checkbox"/> Radiology | <input type="checkbox"/> Medical Assistant |
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Laboratory | <input type="checkbox"/> Medical Records |
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Dental |
| <input type="checkbox"/> Billing/ Coding | <input type="checkbox"/> Preceptor: _____ | <input type="checkbox"/> Other _____ |

Career Interest & Objective for NH DOL approval (attach a course description or syllabus):

Preferred date(s) (#1, #2 & #3)

of hours: _____

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> January _____ | <input type="checkbox"/> May _____ | <input type="checkbox"/> September _____ |
| <input type="checkbox"/> February _____ | <input type="checkbox"/> June _____ | <input type="checkbox"/> October _____ |
| <input type="checkbox"/> March _____ | <input type="checkbox"/> July _____ | <input type="checkbox"/> November _____ |
| <input type="checkbox"/> April _____ | <input type="checkbox"/> August _____ | <input type="checkbox"/> December _____ |

Immunizations (List dates below and attach record to form)

- | | | |
|--|--|---|
| <input type="checkbox"/> MMR (Measles, Mumps & Rubella)
1 st : _____
2 nd : _____ | <input type="checkbox"/> Hepatitis B
1 st : _____
2 nd : _____
3 rd : _____ | <input type="checkbox"/> Influenza (Flu Shot)
Date: _____ |
| <input type="checkbox"/> Tdap (Tetanus, Diptheria, Pertussis)
Date: _____ | | <input type="checkbox"/> COVID
Date: _____ |

Return the following:

- Unpaid Internship Agreement
- Confidentiality Agreement
- Proof of Immunizations
- Signed student handbook page 24

Return to:

Human Resources – Mid-State Health Center
 101 Boulder Point Drive, Suite 1
 Plymouth, NH 03264
 jpheace@midstatehealth.org

***School requirements: current affiliation agreement, Certificate of Insurance, NH DOL approval**